Appendix H

Regulatory and Legal Background Information

During the course of gathering information and ideas for this summit, interviews were conducted of summit participants. Below is a listing of several additional issues that were raised, along with some explanatory background, and where appropriate, a discussion of concurrent relevant activities of DHFS or other agencies/organizations.

1. Some individuals raised the issue of guardianship and the limitations of the guardian in protecting/controlling the ward. What are the limits of guardianship?

It is certainly an accurate description of Wisconsin (and every other state's laws) to acknowledge that a guardianship can not guarantee control or supervision of an individual. A guardian, appointed in Wisconsin under sec. 880.33, Stats., is appointed to "secure necessary care, services or appropriate protective placement on behalf of the ward," sec. 880. 38(2), Stats. A guardian is not, however, responsible for the day to day actions of his or her ward. Indeed, a guardian has immunity for actions done in good faith (sec. 880.39, Stats.) In addition, a guardian, like the entire adult protective services (APS) system itself, has the tricky responsibility of trying to *balance* the ward's right to least restrictive environment and least restrictions on liberty (sec. 55.001, Stats.,) with their concomitant obligation to protect them from abuse, neglect and exploitation (Id.) Wisconsin law, like most states, is decidedly vague in its listing of tasks and responsibilities of the guardian, particularly the guardian of the person. Other than the "duty to secure necessary care, services or appropriate protective placement" (sec. 880.38(2), Stats.) and the obligation to file an annual report on the status of the guardian, (sec. 880.38(3), Stats.,) the statutes' only other guidance is to make decisions in the "best interests" of the ward. This raises more questions than answers. For example, a guardian who makes decisions prohibiting a ward from smoking cigarettes, engaging in sexual activities, having certain visitors, participating in certain activities, and other arguably non-medical, non-residential choices may be entirely correct (and indeed responsible) in making those decisions – as being well thought-out and squarely "in the best interests" of the ward. In other situations, a guardian making some of those decisions has clearly *not* done so in the ward's best interests and should be challenged (informally or through a court proceeding, if necessary).

In situations of the ward acting out aggressively in a facility or while receiving care from a community-based provider, a guardian's job, not unlike the provider's, is a difficult one. A guardian must work with community providers or a facility to assert his or her ward's right to be safe and yet have the least possible restrictions on his or her liberty. This may mean working with the providers to identify possible methods of controlling challenging behaviors whether through some (legal!) passive restraints, medications, behavioral therapies, diversion tactics, etc. A guardian should not readily accept a provider's "we're too busy" to try that response nor should they quickly rush to the courthouse to pursue additional authority under ch. 55 to impose highly restrictive protective services or placement (including medication) on the ward.

[NOTE: There are certain (admittedly cumbersome and not necessarily successful) remedies in situations where a concerned individual (e.g., a provider, another family members, county APS

worker, etc.) believe that a guardian is doing a poor job (either by acts of omission – e.g., not responding to a facility's requests for decisions, consent, etc., or by acts of commission – e.g., prohibiting certain actions, abusing the ward him/herself, etc.). These include, for example: (a) calling or writing the probate court and asking for a guardian ad litem to be appointed to investigate; (b) contacting the county corporation counsel or APS unit and asking them to investigate; (c) petitioning the court to remove the guardian; and/or (d) seeking legal counsel for the ward to challenge the actions of the guardian, reinstate some rights, etc.]

One particular, unique problem often relayed in this area, is a guardian's authority to consent to psychotropic medications (often used for behavioral problems) for a ward. It had long been the interpretation of DHFS, advocates and others that a guardian had authority to consent to psychotropic medications for a non-protesting ward (i.e., consenting or not voicing any protest). Conflictingly, an Attorney General opinion issued December 1999, and then revised slightly and reissued December 2000, (OAG 5-99) has disagreed with that interpretation and opined that it may be a constitutional violation if a guardian consents to psychotropic medications for a ward, absent specific court authority under sec. 880.07(1m), Stats. Because of this interpretation, a work group of individuals from DHFS, advocates and provider groups are working to develop legislation that would: (a) clarify that guardians *may* consent to psychotropic medications for non-protesting wards; and (b) develop a less cumbersome system for court proceedings to authorize guardian consent for psychotropic medications for protesting wards. The latter would also include a revised definition of "not competent to refuse psychotropic medications," (sec. 880.01(7m), Stats.,) that would include the elderly with Alzheimer's or other dementias. Under current law, an individual must be diagnosed as having "mental illness" for these provisions to be available; thus, under current law, individuals with developmental disabilities or other dementias would never even meet the standards for these provisions.

- *See* attachment, excerpt from DHFS's Chapter 55: The Wisconsin Protective Services System and its Application, December 1994, by Attorney Roy Froemming, pages 47-48.

NOTE: The Elder Law Section of the State Bar of Wisconsin has prepared and submitted to the legislature a comprehensive proposal for reform of Wisconsin's guardianship law. This proposal has been reviewed by a sub-committee of the DHFS APS Modernization Committee. Many of their suggestions were accepted by the Elder Law Section and it is currently being drafted. This proposal would address some of the above issues, including that of psychotropic medications. Similarly, separate legislation has been requested by Rep. Jeff Plale that would also permit guardians to consent to psychotropic medications for any non-protesting wards and provide a simpler, less cumbersome procedure for protesting wards. This proposal would also specifically be applicable to wards with Alzheimer's Disease or other dementias.

2. Nursing homes, community-based residential facilities and crisis centers are often asked – on very short notice – to "quickly" admit someone to their facility due to behavioral problems. What criteria are currently in place that permit – or impede – such admissions/transfers?

HFS regulations allow CBRF's and nursing homes to admit indviduals on short notice (and for a limited period of time) in certain situations. For a respite care resident admitted to a CBRF, the

admissions agreement must be dated and signed within 48 hours after admission. The admission agreement for respite care is required to have all of the elements of a regular admission agreement (services, rate, source of payment, security deposit, conditions for discharge or transfer and refunds), with the exception of information relating to entrance and bedhold fees. HFS 83.16(2).

A registered nurse or physician shall complete a **comprehensive resident assessment** of the person prior to admission or on the day of admission. This assessment shall include evaluation of the individual's medical, nursing, dietary, rehabilitative, pharmaceutical, dental, social and activity needs. HFS 132.70(2)(a)1. It shall also contain a statement from the attending physician that the person is free from tuberculosis and other clinically apparent communicable diseases. Finally, the assessment shall include the attending physician's plans for discharge. The registered nurse shall (with verbal agreement of the attending physician) develop a written **plan of care** based on the comprehensive resident assessment. HFS 132.70(2)(a)2.

If a person will be receiving respite care in a CBRF for more than 48 consecutive hours or will be placed in a CBRF periodically, a **service plan** identifying the individual's needs and abilities is required. This service plan is to be developed within 48 hours after admission. For an emergency admission made by a county agency, the CBRF shall attempt to obtain the resident's assessment information from the county agency within 5 days after admission.

Similar requirements apply for 'short notice' admissions to nursing homes. An individual being admitted (or that individual's guardian) must sign an acknowledgement of having received a **statement on or before the day of admission which contains at least the following information:**

- An indication of the expected length of stay, with a note that responsibility for care of the resident reverts to the resident or other responsible party following the designated length of stay;
- An accurate description of the basic services provided by the facility, the rate charged for those services, and the method of payment for them;
- Information about all additional services regularly offered but not included in the basic services and where a statement of the fees charged for these services can be obtained;
- The method for notifying residents of a change in rates or fees;
- Terms for refunding advance payments in case of transfer, death or voluntary or involuntary termination of the service agreement;
- Conditions for involuntary termination of the service agreement;
- The facility's policy regarding possession and use of personal effects; and
- In summary form, the residents' rights recognized and protected by HFS 132.31 and all facility policies and regulations governing resident conduct and responsibilities.

A **comprehensive resident assessment** shall be completed prior to or on the day of admission. The assessment shall include a summary of all the major needs of the person and the care to be provided, a statement from the attending physician that the person is free from tuberculosis and other clinically apparent communicable diseases and the attending physician's plans for discharge.

The registered nurse, with verbal agreement of the attending physician, shall develop a written **plan of care** for the person being admitted prior to or at the time of admission. The plan of care shall be based on the comprehensive resident assessment, the physician's orders, and any special assessments made.

The facility is required to send a copy of the comprehensive resident assessment, the physician's orders and the plan of care to the person's attending physician. The attending physician shall sign the assessment and plan of care within 48 hours after the person is admitted.

3. Nursing homes often feel that they are in a double bind in dealing with aggressive residents: there are limits on what kinds of restraints/controls they put on these individuals, yet at the same time, they are often cited when this individual becomes aggressive and harms him/herself or others. What are the current nursing home regulatory criteria?

Physical Restraint and Isolation

A service provider's use of isolation, seclusion and physical restraint is regulated by s. 51.61(1)(i), Stats., and HFS Chapter 94, 'Patient Rights.' (**Note:** The use of isolation, seclusion or physical restraint may be further limited or prohibited by licensing or certification standards for that provider. HSF 94.10 –Annot.) Any service provider using isolation, seclusion or restraint is required to have a written policy in place. The policy must ensure that the safety and dignity of the individual is protected and that there is frequent monitoring by trained staff to care for bodily needs as may be required. The status of the individual shall be reviewed once every 30 minutes.

Patients have a presumptive right to be free from isolation or physical restraint. Isolation or physical restraint is only to be used in emergency situations (when it is likely that the patient may physically harm him/herself or others) or in cases in which it is part of the individual's treatment plan. Isolation or physical restraint may only be used when less restrictive measures are ineffective or not feasible and shall be used for the shortest time possible. § 51.61(1)(i)1, Stats. Isolation or restraint may not be used as punishment, for the convenience of staff or as a substitute for an active treatment program or any particular treatment. HFS 134.60(5)(b)4.

The facility director specifically designates physicians who are authorized to order isolation or restraint as well as licensed psychologists who are authorized to order isolation. Authorization is to be in writing unless it is an emergency, in which case written authorization is to be obtained from the physician or psychologist within one hour. Emergency isolation or restraint may not be continued for more than 24 hours without a new written order.

Involuntary Discharge of Residents

A nursing facility may discharge or transfer a resident from its facility only under limited circumstances. §49.498(4)(a), Wis. Stats. A resident may be transferred or discharged if the department finds that the transfer or discharge is for welfare of the resident or of other residents. §50.03(5m)(a)4, Wis. Stats.

The department shall provide written notice to the facility and to any resident sought to be removed, to the resident's guardian, if any, and to a member of the resident's family, where practicable, prior to the removal. The notice shall state the following:

- the basis for the order of removal; and
- the right of the resident (or the resident's guardian) to a hearing.

If the resident challenges the removal, he or she is entitled to a hearing prior to removal. At the hearing, the department/facility has the burden of proving that a factual basis exists for the removal.

Sec. 50.03(5m)(c), Wis. Stats., states that the department **shall** offer removal and relocation assistance to residents removed. In addition, residents are allowed to choose their final alternative placement and are entitled to assistance in transferring to such place. No resident may be forced to remain in a temporary or permanent placement except pursuant to the procedures provided under s. 55.06, Stats., for protective placement.

4. The emergency detention laws in chs. 51 and 55 do not appear to be well-designed for people with dementia or people with mental illness. Are they? What criteria or methodology is there for a third-party petition for an evaluation?

The laws of chs. 51 and 55, Stats., should be carefully considered before use. The major difference between the two laws is their purpose – what one wants the subject individual to receive as a result. Ch. 51 is for individuals in acute situations where the goal is for the individual to end up in an in-patient psychiatric unit, as opposed to a long-term residential placement in an adult family home, CBRF or nursing home; if the latter, ch. 55 should be used. Ch. 51, Stats., is pursued to use the law to obtain desired treatment and services. Thus, ch. 51 is for individuals with acute problems for whom involuntary acute services or treatment (e.g., medication) is sought; ch. 55 is for involuntary long-term residential placements.

The standards for the "regular" (i.e., not the emergency) ch. 55 protective placement of 55.06(2), Stats., are:

- The subject has a primary need for residential care and custody;
- The subject is incompetent (finding within the last twelve months or else it must be re-established);
- As a result of developmental disabilities, infirmities of aging, chronic mental illness or other like incapacities, the subject is totally incapable of providing for his or her own care and custody as to create a substantial risk of serious harm to self or others; and
- The subject has a disability which is permanent or likely to be permanent.

For *emergency* protective placements, under sec. 55.06(11), Stats., the standard is that "the individual will suffer irreparable injury or death or will present a substantial risk of serious physical harm to others as a result of developmental disabilities, infirmities of aging, chronic mental illness or other like incapacities if not immediately placed." To effectuate the emergency placement, a police officer, the guardian or an authorized representative of the sec. 55.02-

designated board, who believes the above standard is met, may take the individual into custody and transport the individual to an appropriate medical protective placement facility. He or she must prepare a statement swearing to the above criterion and then immediately file a petition for protective placement with the court. A "probable cause" hearing is required within 72 hours and if found, a placement can be held for up to 3 days. There must, thereafter, be a final hearing on the protective placement petition. Clearly, some individuals pursue an emergency protective placement without the goal being long-term residential placement. Ultimately though, if probable cause is found within the 72 hours, the individual can be held for 30 days, during which time the hearing on the petition for the *permanent* protective placement must be held. Thus, an *emergency* protective placement *could nevertheless be pursued* for individuals for whom evaluation and assessment – in a long-term residential facility – is sought.

For ch. 51 civil commitments, a subject individual must meet one of the following three criteria: (a) have either mental illness, developmental disabilities or be drug dependent; AND (b) be a proper subject for treatment; AND (c) meet one of five standards for dangerousness – see sec. 51.15(1)(a)1-5, Stats. The process can be initiated in one of three ways:

(a) An Emergency Detention – police either have to see it or based on reliable witness, AND police then pick individual up and take him/her to a hospital or other state-approved treatment facility; or

(b) Three-party petition – three people get together and request an evaluation. One person has to have actual knowledge and this must be processed through county corporation counsel; or

(c) Treatment director's hold – an individual is already there on a voluntary basis and asks to leave. If the staff feels he or she shouldn't leave, they can file a petition to start the proceeding.

Once started, there must be a probable cause hearing within 72 hours (not counting weekends or holidays) with possible dispositions either settlement agreements; court orders for medication and/or treatment; or conversion to protective services or placement proceedings or to an alcoholism commitment.

NOTE: In our opinion, ch. 51 is not appropriate for individuals with a diagnosis of Alzheimer's or other dementia as this does not meet the definition of "mental illness, developmental disabilities or drug dependent" and therefore should not be used.

Under both ch. 51 and 55 procedures there are numerous procedural protections including a right to a guardian ad litem, right to cross-examine witnesses, right to independent medical examination, right to jury trial, etc. Under ch. 55, and individual may request defense counsel; under ch. 51, defense counsel is mandatory.

NOTE: Rep. Jeff Plale has requested a legislative draft that would permit guardians, in certain circumstances, to admit their wards to psychiatric units for assessments.

5. How can an individual with dementia, who is under guardianship, be admitted to a psychiatric unit?

In the 1985 cases, *State ex rel. Watts v. Combined Community Services Board*, 122 Wis. 2d 65, 91 (1985), the Wisconsin Supreme Court struck down as a denial of equal protection, two subsections of ch. 55 (secs. 55.06(9)(d) and (e), Stats.,) that gave authority to a guardian to authorize admission of a person under protective placement for inpatient acute psychiatric diagnosis or treatment. As a result of that decision, **the procedures and standards for commitment under ch. 51, Stats., must be used for involuntary psychiatric hospitalization of people who are protectively placed** under ch. 55. Note that secs. 55.06(9)(d) and (e), Wis. Stats., are still "on the books," (17 years later!) but are unconstitutional and may not be used.

The court in *Watts* went on to hold the guardians of people who are not also protectively placed also lack authority to consent to mental hospitalization of individuals who do not consent to the hospitalizations. Stating the guardianship itself does not justify involuntary hospitalization, the court again held that the commitment standards and procedures *must be followed.* Similarly, a health care power of attorney also may not be used for acute psychiatric inpatient admissions (secs. 155.20(2) and (3), Stats.).

Under sec. 51.10(8), Wis. Stats., an individual who has a guardian of the person appointed based on a finding of incompetence may be voluntarily admitted to an inpatient treatment facility **only if both the guardian and person consent**. It is clear from this that the **guardian's consent is necessary for any voluntary admission;** an admission based on the consent of the person alone is illegal. It is also clear that **the guardian has no power to authorize admission if the person objects in any way.**

An issue remains under both the statutes and *Watts* as to the kind of "consent" that must be obtained from the person him or herself to make admission possible. A requirement of consent generally cannot be met by a person incapable of giving consent. A "consent" from a person under guardianship is therefore presumably valid only if the person is capable of expressing an understanding of the advantages and disadvantages of hospitalization and the alternatives to it.

Sec. 51.10(4m), Stats., allows "voluntary" admission of a person if a physician certifies that he has informed the person of his or her right to leave, the benefits and risks of treatment and his or her right to "least restrictive treatment." The probate court must be informed within 24 hours (not counting holidays and weekends), a guardian ad litem *must* be appointed and must visit within 48 hours to inform the person of his or her rights and determine if he or she wants less restrictive treatment, and a hearing must be held within 7 days to determine if the person wants to leave the facility. This process allows for the admission and retention of people who express no opinion about the placement. While this procedure is probably used in practice to admit people incapable of giving valid consent, this use is probably inconsistent with (i.e., in violation of) the *Watts* decision.

Under sec. 51.01(7), Stats., the treatment director of a psychiatric hospital may admit a person when there is "reason to question" his or her competence. The treatment director must

apply for appointment of a guardian within 48 hours and the person may remain at the facility pending appointment of a guardian. However, admission and retention of the person under this section, especially beyond the 48 hour period, seems inconsistent with the *Watts* decision.

The above is adapted from DHFS's Chapter 55: The Wisconsin Protective Services System and its Application, December 1994, by Attorney Roy Froemming, pages 75-76.

6. What is the status of the law regarding individuals with dementia and on-going sexual relationships?

The capacity to consent to sexual contact or sexual intercourse is defined in the laws on sexual assault, sec. 940.225, Stats., which make it a crime for any person to have sexual contact with another person who has a mental illness or deficiency which makes him or her "incapable of appraising his or her conduct," if the person making the contact knew about the condition." (Sec. 940.225(2)(c), Stats.) Although Wisconsin courts have not specifically defined this standard, the Wisconsin Court of Appeals did conclude that the statute is not unconstitutionally vague as it provides fair notice of the prohibited conduct and an objective standard for enforcement of violations. *State v. Smith*, 215 Wis. 2d 84, (Wis. Ct. App. 1997).

The New Jersey Supreme Court – in a case involving a young woman with mental retardation, not an elder with dementia – adopted a two-part test for capability to consent to sexual contact:

- The person must understand the "distinctively sexual nature of the conduct." In other words, the person must be able to understand the physical nature of sexual acts and have some understanding that they enjoy a special status as "sexual." The court stated that this does not require an understanding of consequences, such as pregnancy or disease.
- The person must understand that his or her body is private and that he or she has the *right* to refuse to engage in sexual activity. *Self-control* is not the issue, only an understanding of the right to say "no."

In adopting this narrow test for capacity, the New Jersey court was concerned that an overly-protective interpretation would risk depriving people with mental disabilities of legitimate sexual expression, noting that people with disabilities (in that case, mental retardation), have the right to pursue happiness and fundamental privacy rights (including, in that case, procreation and contraception). *State v. Olivio*, 123 N.J. 597, 589 A.2d 597 (1991).

Other courts have set a higher standard for capacity to consent. New York, for example, requires an understanding of "the moral quality" of the conduct in the framework of the societal environment and taboos to which a person will be exposed." *People v. Easley*, 42 N.Y.2d 50, 396 N.Y.S. 2d 635, 364 N.E.2d 1328, 1332 (1977). The person need not *comply* with social taboos, only understand them.

Whatever the standard for an individual, it is clear that a guardian MAY NOT PROVIDE CONSENT FOR A PERSON WHO CANNOT CONSENT FOR HIMSELF OR HERSELF. Unless consent comes from the person, any sexual contact is a criminal assault.

NOTE: The fact that a person is under guardianship does not answer the question of whether he or she can consent to sexual contact. The standard for guardianship (incapable of caring for self due to mental incapacity) is *different* from the test for consent to sexual contact, and in practice there are many people under guardianship experiencing consensual, and positive, sexual relationships. Ideally, their right to consent should be preserved when the guardianship is established through a limited guardianship. Where this is not done, inappropriate restriction of rights and on-going conflict are likely to result. While there is no clear law on the subject, it is likely that where the person has the ability to appraise his or her conduct and chooses to engage in sexual contact, his or her right to do so is protected by the constitutional right to privacy. A guardian, acting with the authority of the state, can interfere with that choice only if there is a compelling reason to do so, such as protection from physical harm or (perhaps) emotional trauma, or where the sexual contact would be criminal (e.g., where the contact is with an institutional employee). Under this analysis, for example, moral or religious opinions of the guardian and preference as to partner would not be valid reasons for interference in the person's choice.

The above is adapted from from DHFS's Chapter 55: The Wisconsin Protective Services System and its Application, December 1994, by Attorney Roy Froemming, pages 57-58.

7. What is the criteria for the domestic abuse mandatory arrest law?

Wisconsin's Mandatory Arrest Law was created by 1987 Wisconsin Act 346. Sec. 968.075 of the Wisconsin Statutes directs law enforcement agencies to "develop, adopt and implement written policies regarding arrest procedures for domestic abuse incidents."

Sec. 968.075(1)(a), Wis. Stats., defines "domestic abuse" as follows:

"Domestic abuse" means any of the following engaged in by an adult person against his or her spouse or former spouse, against an adult with whom the person resides or formerly resided or against an adult with whom the person has a child in common:

1) Intentional infliction of physical pain, physical injury or illness.
2) Intentional impairment of physical condition.
3) A violation of s. 940.225(1), (2) or (3). [Sexual Assault Statute]
4) A physical act that may cause the other person reasonably to fear imminent engagement in the conduct described under subd. 1., 2. or 3.

Although what is meant by infliction of "physical pain, injury, or illness" is relatively unambiguous, the meaning of "residing together" for purposes of the domestic violence statute is not as clear. It is agreed that the statute applies to those individuals who are in relationships with others either by virtue of a familial connection or by living together. Historically, the language has been interpreted broadly, including roommates who live together in university residence halls. 79 Op. Atty. Gen. Wis. 109. Although not explicitly stated, it is likely that the statute would also apply to roommates in nursing homes and Community Based Residential Facilities (CBRF's) as well as residents who have separate bedrooms but share common living quarters.

The law's purpose is to hold abusers accountable for their conduct and to provide increased protection for victims of domestic violence. The Legislature expressly stated this in its creation of the Act.

Sec. 968.075(2), Stats., referring specifically to domestic violence incidents, describes the circumstances in which an arrest is required. It reads as follows:

> **(2) CIRCUMSTANCES REQUIRING ARREST.** (a) Notwithstanding s. 968.07 and except as provided in par. (b), a law enforcement officer shall arrest and take a person into custody if:
> 1. The officer has reasonable grounds to believe that the person is committing or has committed domestic abuse and that the person's actions constitute the commission of a crime; and
> 2. Either or both of the following circumstances are present:
>   a. The officer has a reasonable basis for believing that continued domestic abuse against the alleged victim is likely.
>   b. There is evidence of physical injury to the alleged victim.

If there is no injury or there is not a reasonable basis to believe that continuing domestic abuse is likely, arrest is not required. If the officer decides not to make an arrest, he or she must submit a written report explaining the reasons for the decision to the district attorney's office. That section of the statute, sec. 968.075(4), Stats., reads as follows:

> **(4) REPORT REQUIRED WHERE NO ARREST.** If a law enforcement officer does not make an arrest under this section when the officer has reasonable grounds to believe that a person is committing or has committed domestic abuse and that person's acts constitute the commission of a crime, the officer shall prepare a written report stating why that person was not arrested. The report shall be sent to the district attorney's office, in the county where the acts took place, immediately after investigation of the incident has been completed. The district attorney shall review the report to determine whether the person involved in the incident should be charged with the commission of a crime.

To ensure that the law enforcement officer acts appropriately in making the decision, the statute affords him or her protection from any liability that arises from the decision. Sec. 968.075(6m), Wis. Stats., provides this protection. It states the following:

> **(6m) OFFICER IMMUNITY.** A law enforcement officer is immune from civil and criminal liability arising out of a decision by the officer to arrest or not arrest an alleged offender, if the decision is made in a good faith effort to comply with this section.

The purpose of sec. 968.075, Stats., is to protect victims of domestic violence. However, in those situations in which arrest is required, officers have options concerning whether to place the offender in county (jail) or another setting that ensures protection of the victim. Brown County, Wisconsin, has a creative collaborative systems response to mandatory arrest.

For example, when a custodial arrest (jail) would not be appropriate because the mental status of the offender, i.e., suspected or known Alzheimer's or dementia associated with memory loss and disorientation, the law enforcement officer could contact the officer in charge to explain the situation, then call the local crisis center to request that a social worker assess the offender's mental status. If the determination is made that physical placement in the human service system is more appropriate than secure custody (jail), the social worker will facilitate such a placement and will contact local support services for the victim. The officer will still submit the report to the district attorney for review and a charging decision. Local facilities (nursing homes, CBRF's, AFH's) should be identified in advance as placement resources for offenders in such cases.

Compiled by Attorneys Smith Carlson, DHFS Office of Legal Counsel and Betsy Abramson, Elder Law Consultant – May 2002